

## AMERICAN INDIAN INFANT HEALTH INITIATIVE (AIHI) DATABASE FORM

FSW/CHR complete within first quarter of service and submit with an initial Quarterly Progress Report (DHS 4496).

|             |                            |
|-------------|----------------------------|
| Clinic name | Enrollment date (mm/dd/yy) |
|-------------|----------------------------|

### Client/Mother (MOB) Data

|   |   |  |
|---|---|--|
| MOB ID number   | MOB date of birth   | Age  |
| American Indian<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | Education—highest grade completed   | Still in school<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Marital status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated | Gravida (including the current pregnancy)    Para   |  |
| Currently pregnant<br><input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, complete the following:                                       | EDC (mm/dd/yy)  | Date of first prenatal visit (mm/dd/yy)    Trimester:<br><input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third |
| Recently gave birth<br><input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, complete the following:                                      | Date of birth   | Birth weight<br>_____ lbs.    _____ oz.  |
| Type of birth<br><input type="checkbox"/> Singleton <input type="checkbox"/> Multiple   | Gestation<br><input type="checkbox"/> Preterm (<37 weeks) <input type="checkbox"/> Full term (38–42 weeks) <input type="checkbox"/> Post term (43+ weeks) |  |

### Birth Complications (Check all that apply.)

|   |  |
|---|--|
| <b>Mother</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Medical (including C-section)<br><input type="checkbox"/> Drug/alcohol use-related<br><input type="checkbox"/> Infections<br><input type="checkbox"/> Other (explain): _____   | <b>Child</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Medical<br><input type="checkbox"/> Drug/alcohol exposure<br><input type="checkbox"/> Developmental<br><input type="checkbox"/> Other (explain): _____ |
| Living with (check all that apply):<br><input type="checkbox"/> Alone <input type="checkbox"/> Father of baby (FOB) <input type="checkbox"/> Parent(s)/extended family <input type="checkbox"/> Friend(s)<br><input type="checkbox"/> Spouse/Partner (other than FOB) <input type="checkbox"/> Other (explain): _____ |  |
| Source of income (check all that apply):<br><input type="checkbox"/> Employment <input type="checkbox"/> TANF <input type="checkbox"/> Father of baby (FOB)<br><input type="checkbox"/> Parent(s)/extended family <input type="checkbox"/> Other (explain): _____   |  |
| Has child(ren) under age 5 (NOT including the newborn described above)<br><input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, complete the following:   |  |
| How many?    How old?   |  |

### Father (FOB) Data

|  |                          |     |  |  |
|--|--------------------------|-----|--|--|
| American Indian<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Date of birth (mm/dd/yy) | Age | If DOB is unknown, enter estimated age | Involved with pregnancy/child<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|--|--------------------------|-----|--|--|

### Assessments (Maternal/Child Risk Profile)

☐ Not done (If checked, submit the results in following quarter.)

### Client/MOB Psychosocial Risk Factors (Check all reported and/or observed risks.)

- ☐ None identified
- ☐ \* 1. Substance abuse or positive toxicity:    ☐ with    **OR**    ☐ without treatment (explain): \_\_\_\_\_
- ☐ \* 2. Maternal Hx of mental illness or developmental delay (parent)
- ☐ \* 3. Maternal Hx of child abuse, rape, molestation, or incest (as a victim)
- ☐ \* 4. Age <18 years or >40 years
- ☐ 5. Single, separated (legal or geographical), divorced
- ☐ 6. Self or partner unemployed or seasonal employment
- ☐ 7. Education <12<sup>th</sup> grade or illiterate (English or other language)
- ☐ 8. Inadequate income (<200% FPL or on Medi-Cal)
- ☐ 9. Unstable housing (homeless, frequent moves, overcrowded, multifamily)
- ☐ 10. No telephone or message only
- ☐ 11. Lack of transportation/public transport or dependent on others
- ☐ 12. First-time mother
- ☐ 13. Late (after third trimester), inadequate/sporadic, or no prenatal care
- ☐ 14. Hx of therapeutic abortion (actual or contemplated) or multiple miscarriages
- ☐ 15. Depression or suicidal ideation (past or present)
- ☐ 16. Child(ren) in foster home placement (past or present) or CPS involvement
- ☐ 17. Hx of domestic/family violence or rape/sexual assault (as a victim)
- ☐ 18. Other (e.g., no support system/person, unplanned pregnancy, unrealistic expectation of child development)  
(explain): \_\_\_\_\_

\* Each of factors 1–4 is worth 10 points each.

Each of factors 5–18 is worth 1 point.

Refer client to AIHI if she: (1) scores 10 or higher; or (2) scores 5–9 with significant medical risk(s) (see "Medical Risk Factors" on the following page.

Score

**Assessments (Maternal/Child Risk Profile)** (continued)**Medical Risk Factors** *(This section to be completed by PHN.)***Client/MOB**

- ☐ No risk factors
- ☐ Hx of birth of preterm (<38 weeks), LBW (<2,500g), or SGA infant (explain): \_\_\_\_\_
- ☐ Chronic medical conditions or complications (explain): \_\_\_\_\_
- ☐ Significant communicable disease and/or tuberculosis (explain): \_\_\_\_\_
- ☐ Previous infant mortality (explain): \_\_\_\_\_
- ☐ Other (e.g., gestational diabetes) (explain): \_\_\_\_\_

**Infant (0–1 year)**

Infant in home?

- ☐ Yes (DOB [mm/dd/yy: \_\_\_\_\_]) ☐ No

If yes, complete the following:

- ☐ No risk factors
- ☐ Failure to thrive (explain): \_\_\_\_\_
- ☐ Premature (<38 weeks), LBW (<2,500g), or SGA (explain): \_\_\_\_\_
- ☐ Acute or chronic major medical condition (explain): \_\_\_\_\_
- ☐ Known or at risk for developmental delay (explain): \_\_\_\_\_
- ☐ Abused, neglected, or not safe (explain): \_\_\_\_\_
- ☐ Significant communicable disease and/or tuberculosis (explain): \_\_\_\_\_
- ☐ Fetal exposure to drug(s) (explain): \_\_\_\_\_
- ☐ Other (explain): \_\_\_\_\_

**Toddler (1–2 years)**

Toddler in home?

- ☐ Yes (DOB [mm/dd/yy: \_\_\_\_\_]) ☐ No

If yes, complete the following:

- ☐ No risk factors
- ☐ Acute or chronic major medical condition (explain): \_\_\_\_\_
- ☐ Abused, neglected, or not safe (current) (explain): \_\_\_\_\_
- ☐ Significant communicable disease and/or tuberculosis (explain): \_\_\_\_\_
- ☐ Other (explain): \_\_\_\_\_

**Preschooler (3–4 years)**

Preschooler in home?

- ☐ Yes (DOB [mm/dd/yy: \_\_\_\_\_]) ☐ No

If yes, complete the following:

- ☐ No risk factors
- ☐ Acute or chronic major medical condition (explain): \_\_\_\_\_
- ☐ Abused, neglected, or not safe (current) (explain): \_\_\_\_\_
- ☐ Significant communicable disease and/or tuberculosis (explain): \_\_\_\_\_
- ☐ Other (explain): \_\_\_\_\_

Completed by

Date last updated